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## Transparency: A Prescription Against Malpractice

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**B**Y HELPING TO WEED OUT substandard physicians, the National Practitioner Data Bank will reduce the number of botched surgeries, missed diagnoses, adverse drug reactions, and resulting high medical bills. Will the Data Bank weed out all incompetent and unprofessional physicians? No, it is not a panacea. After 4 years, malpractice has not been eliminated. Patients are still injured unnecessarily by licensed physicians in the hospitals and HMOs of our country. Based on the results of the study by Oshel and colleagues, the Data Bank, which was created by Public Law 99-660, is working. The current law is a good start and it can be improved.

The Data Bank has created a national foundation for an effective system to share information. It will help solve a problem that was not and could not be handled by States or health care institutions alone. States possess different systems, different rules, different operations, and different traditions. Until the Data Bank was created, America had no system for protecting the public from physicians who seek to evade State systems.

The Data Bank has created significant financial incentives for providers to act against incompetent and unprofessional physicians. If you run a hospital, you are expected to consult the Data Bank for all new staff appointments and at regular intervals for all physicians. If you don't check the Data Bank before credentialing a physician, and there is malpractice and an ensuing lawsuit, the facility is imputed to have known the physician's track record from the Data Bank.

There are 800,000 such queries annually. With patients and payers assuming that hospitals have knowledge about their staffs, failures become the hospital's responsibility. In our increasingly competitive system of medical care, hospitals will be forced to be responsible for how their physicians practice medicine.

We do not know how often hospitals and HMOs are acting upon the information they receive from the

Data Bank. We do not know whether the 30-day threshold for reporting suspensions of privileges has resulted in a epidemic of 29-day suspensions. The health industry covers these processes with secrecy.

In my judgment, if the health care system is to be built on the principle of consumer choice, consumers must have ready access to reliable, comparative information on quality. It's not enough to give consumers information on the quality of health insurance plans. A "plan" may be a key component of the health care system from the viewpoint of economists, but consumers are more interested in the quality of care provided by physicians, hospitals, and clinics. In fact, consumers often choose their health plans because of the physicians the plan will let them see.

A health care system erected on top of a rotten foundation of skimpy and fragmented information on cost and quality will fail. At the very least, consumers have a right to know more about which health care providers they may wish to avoid. Unfortunately, Americans today have more performance information available to them when purchasing breakfast cereal than when choosing a heart surgeon.

The last thing consumers need is for the Federal Government to withhold vital quality information from them. Yet this is what the Data Bank, as currently authorized, is doing. Consumers are denied access to information that would reveal whether a physician is one of the 13,000 disciplined by a medical licensure board or hospital peer review committee in the past 2 years.

It is indefensible that thousands of reports stored in the Data Bank be kept from the public whose health we seek to protect. To remedy this problem, Representative Scott Klug of Wisconsin and I introduced H.R. 4274 in the last Congress and will introduce similar legislation this year. The legislation will allow the public access to practitioner-specific reports contained in the Data Bank. All adverse actions (revocation or suspension of licenses and privileges) and malpractice payments concerning practitioners for whom the Data Bank has reports of two or more separate incidents that resulted in malpractice payments would be published.

Despite our progress, adequate inclusion and protection of the patient in our health care system may be far off. By making the Data Bank's

information about malpractice and unprofessional conduct public, we will bring consumers another step toward controlling their own medical care. The

ultimate goal for the Data Bank is transparency, where health professionals share with the public what they know of themselves.

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## Putting the Controversy Aside, How is the Data Bank Doing?

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The views expressed in this commentary are those of the author and do not necessarily represent those of the Office of Inspector General or the Department of Health and Human Services.

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**I**N TODAY'S QUALITY assurance environment, where continuous quality improvement is the dominant tenet, the National Practitioner Data Bank runs against the grain. It seeks to ensure that minimum standards of health care are not breached at a time when the emphasis is on improving the mainstream of care and identifying benchmarks of excellence. It pinpoints people whose knowledge or practice skills, or both, may be questionable at a time when the priority is on improving systems of care offered by health care organizations. It raises the specter of punitive actions at a time when the watchword is collaboration. Therein lies the basis for much of the controversy that surrounds the Data Bank.

Oshel, Croft, and Rodak venture into this highly charged territory and provide us with bundles of useful data. Both critics and advocates of the Data Bank are sure to find information here to bolster their cases. For example, while critics might point out that "only" 5.3 percent of all queries to the Data Bank have resulted in matched reports (which identify practitioners included in the Data Bank), supporters might stress that voluntary queries have increased sharply to the point where by the end of the 4-year period covered they were accounting for more than half of all queries. For those in neither camp, the article helps them sort through the issues and reach more informed assessments.

In the Inspector General's Office we, too, have ventured into Data Bank territory, seeking for the most part to gain understanding of the usefulness and impact of Data Bank reports provided to hospitals and managed care organizations (MCOs) (1-3). For

those hoping the Data Bank succeeds, our findings have been reasonably encouraging. We found, for instance, that 83 percent of hospital officials and 96 percent of MCO officials we surveyed regarded the Data Bank reports they received on practitioners to be useful to them. Moreover, we learned that after some early startup problems, the Data Bank had become a timely, highly accurate source of information.

In regard to the impact of the reports, we found that 2 percent of the Data Bank reports in our sample led hospital officials to make different privileging decisions than they would have made without them and that 3 percent had the same effect on MCO officials. Whether these findings on impact are encouraging or not tends to depend on one's point of view. Critics see them as an indication that queries to the Data Bank rarely affect privileging decisions and are not cost-effective. Supporters are apt to point out that 2-3 percent of reports involve hundreds of practitioners and affect many thousands of patients they serve. They are also likely to point out that the very existence of the Data Bank may deter some unfit practitioners from even applying to hospitals or MCOs for practice privileges.

Our most disturbing findings concern the extent of hospital reporting to the Data Bank. Hospitals, as Oshel and colleagues point out, must report to the Data Bank all adverse actions they take that affect a practitioner's clinical privileges for more than 30 days. Yet, we found that from September 1, 1990, to December 31, 1993, about 75 percent of all hospitals in the United States never reported an adverse action to the Data Bank. Further, we learned that the State-by-State variation in the rate of nonreporting hospitals was considerable—ranging from 93.2 percent in South Dakota to 51.7 percent in New Jersey.

It is, of course, possible that these minimal levels of reporting exist because there are few practitioners with performance problems serious enough to warrant adverse actions by hospitals. That is highly unlikely, however, given recent studies on the numbers of adverse events caused by medical error or negligence (4,5) and given that State medical licensure boards in